STATE OF MAINE

STATE BOARD OF RESPIRATORY CARE PRACTITIONERS

APPLICATION FOR ASSOCIATE PERMIT

Department of Professional and Financial Regulation
Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

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Physical Location: 122 Northern Ave., Gardiner, ME 04345
Website: www.maineprofessionalreg.org

APPLICATION INSTRUCTIONS
FOR AN ASSOCIATE PERMIT

If you are coming from another state and plan to practice in Maine in association with a respiratory care practitioner licensed in Maine for no more than 30 days in a calendar year, you must apply for and receive and Associate permit before you can start working.

Completed applications must be submitted with all of the supporting materials, including fees. Incomplete applications will be returned. Payments may be made in the form of a check payable to Treasurer, State of Maine, VISA, or MasterCard.

If an applicant is licensed in another state the following must be submitted:

- ☐ Application
- ☐ Permit fee $10.00
- ☐ Verification of license in good standing from another state that has licensure requirements equivalent to the requirements of this chapter. (Attachment "A")
- ☐ Written confirmation of applicant's credential from the NBRC. You can reach the NBRC at: 8310 Nieman Road, Lenexa, KS 66214-1579, Telephone # (913) 599-4200. You need to inform the NBRC to send the verification to you.
- ☐ At the time of application, the associate must report all of the dates and locations that the respiratory services will be performed in Maine, which may not exceed 30 days in a calendar year.

If an applicant is certified or registered by the National Board of Respiratory Care and resides in a non-licensure state the following must be submitted:

- ☐ Application
- ☐ Permit fee $10.00
- ☐ Criminal background record check $15.00
- ☐ Verification of being certified or registered by the National Board of Respiratory Care
- ☐ At the time of application, the associate must report all of the dates and locations that the respiratory services will be performed in Maine, which may not exceed 30 days in a calendar year.

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BOARD OF RESPIRATORY CARE PRACTITIONERS
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JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

Email: Cathleen.a.bitz@maine.gov

Notice regarding Social Security Number Disclosure	**Notice regarding Public Information**
The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.	This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State's website.

Associate Permit Application Form

Applicant Name:		
***Applicant Contact Address*:**		
City:	***State:***	***Zip Code:***
County:	***Telephone:***	
Social Security #:	***Date of Birth:***	
1. Applicant Place of Employment: **Name of Facility**		
***Mailing Address of Facility*:**		
City:	***State:***	***Zip Code:***
County:	***Telephone #:***	
Date of Employment under the associate permit:	***From:***	***To:***
Name of Maine licensed respiratory care practitioner who you will be working with:		
License #:	***Telephone #:***	

2. Applicants Place of Employment:(Name of Facility)		
***Mailing Address of Facility*:**		
City:	***State:***	***Zip Code:***
County:	***Telephone #:***	
Date of Employment under the associate permit	***From:***	***To:***
Name of Maine licensed respiratory care practitioner who you will be working with:		
License #:	***Telephone #:***	

PLEASE ANSWER ALL QUESTIONS WITH A YES OR NO, IF YES, PLEASE PROVIDE A DETAILED EXPLANATION ON A SEPARATE SHEET OF PAPER:

Are you currently or have you ever been credentialed or licensed in another State or Territory?

❒ Yes ❒ No

If credentialed or licensed in more than one State, please list each state separately.
(If you are licensed in additional States, please list on a separate piece of paper)

State: _____ Registration #: _____ Date Issued: _____ Expiration date: _____

State: _____ Registration #: _____ Date Issued: _____ Expiration date: _____

Has any State Board governing the practice of respiratory care denied your application for examination or license? ❒Yes ❒ No

Has your credentials or license ever been suspended or revoked by any State? ❒ Yes ❒ No

Have you ever been convicted of a crime, other than a minor traffic violation? ❒ Yes ❒ No

If yes, please submit copy of the court judgment and decision and a detailed explanation of the crime convicted.

Signature of Applicant: _____ Date: _____

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VERIFICATION OF LICENSURE
(Attachment "A")

INSTRUCTIONS: the applicant listed below is applying for licensure to practice respiratory care in the State of Maine. The Maine Board of Respiratory Care Practitioners requests written verification from each state where the applicant holds any certification licensure or other credentials. This is your authority to release any information in your files, favorable or otherwise. ***Please mail this verification directly to the applicant.***

THIS SECTION TO BE COMPLETED BY THE APPLICANT AND FORWARDED TO THE BOARD THAT ISSUED THE LICENSE.

Name of Applicant:		
***Contact Address of Applicant*:**		
City:	***State:***	***Zip Code:***
License #	***State:***	***Issue Date:***
Applicant Signature:_____		

THIS SECTION TO BE COMPLETED BY THE STATE LICENSING BOARD WHERE APPLICANT HOLDS OR HAS HELD LICENSURE AND FORWARDED BACK TO THE APPLICANT.

Type of license held by applicant ☐ Therapist ☐ Technician

Is applicant currently licensed? ☐ Yes ☐ No

If not currently licensed, when did license expire?

License #: _____ Original issue date: _____

Is the applicant considered a respiratory therapist/technician in good standing in your state? ☐ Yes ☐ No

If no, please explain:

Has there been any complaints filed against this applicant resulting in disciplinary action taken? ☐ Yes ☐ No

If yes, please explain: _____

State Official Signature:
Date:
Printed Name:
Title:
Name or Phone Number of State Board:

BOARD SEAL

PHONE: (207)624-8579
(Office Phone)

PRINTED ON RECYCLED PAPER

FAX: (207)624-8637

(207)624-8653 (TTY/HEARING IMPAIRED)

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AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: **(applicant fees being paid for)**		
***Contact Address*:** **(applicant fees being paid for)**		
City:	***State:***	***Zip Code:***
County:	***Telephone:***	
Name of cardholder: **(if other than applicant)**		
***Contact Address*:** **(if other than applicant)**		
City:	***State:***	***Zip Code:***

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

☐ **Visa** ☐ **MasterCard**_____
Card number

Expiration date: _____/_____/_____ in the amount of: $_____

Signature: _____ Date: _____/_____/_____

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